Illinois Department of
Healthcare and Family Services

WAIVER PROGRAM PROVIDER AGREEMENT FOR PARTICIPATION IN THE ILLINOIS MEDICAL ASSISTANCE PROGRAM

WHEREAS, _____
Full Legal as well as any Assumed (d.b.a.) name
_____ (HFS Provider Number, if applicable)
hereinafter referred to as "the Provider", is enrolled with the Illinois Department of Healthcare and Family Services hereinafter referred to as "HFS", as an eligible provider in the Medical Assistance Program; and

WHEREAS, the Provider is enrolled with _____
Name of Waiver Agency
(hereinafter referred to as "Waiver Agency") as a provider in the _____ ; and
Name of Waiver Program

WHEREAS, the Provider wishes to submit claims for services rendered to eligible Heatlthcare and Family Services clients:

NOW THEREFORE, the Parties agree as follows:

1. The Provider agrees, on a continuing basis, to comply with all current and future program policy provisions as set forth in any applicable Program handbooks/agreements with the appropriate administering Waiver Agency. HFS or Waiver Agency, as appropriate, shall notify the Provider of changes in policy 30 days before the effective date of the change unless there is an emergency, as defined in the Administrative Procedure Act, or the change is to comply with State or Federal law or regulation.

2. The Provider agrees, on a continuing basis, to comply with applicable licensing or certification standards as contained in State laws or regulations.

3. The Provider agrees to comply with Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and regulations promulgated thereunder which prohibit discrimination on the grounds of sex, race, color, national origin or handicap.

4. The Provider agrees, on a continuing basis, to comply with Federal standards specified in Title XIX of the Social Security Act, and also with all applicable Federal and State laws and regulations.

5. Provider agrees that HFS payments for Medicaid services rendered by the Provider shall be voluntarily assigned to the administering Waiver Agency which will then arrange for payment to the Provider as outlined in 1902 (a) (27) and (a) (32).

6. Payments to the Provider under this agreement shall constitute payment in full. Any payments received by the Provider from other sources shall be shown as a credit and deducted from the Provider's charges.

7. The Provider agrees to be fully liable for the truth, accuracy and completeness of all claims submitted electronically or on hard copy for payment. Furthermore, the Provider agrees to review, affix an original signature, and retain in their files the billing certification. Any submittals of false or fraudulent claim or claims or any concealment of a material fact may be prosecuted under applicable Federal and State laws.

8. The Provider agrees to maintain all records necessary to disclose fully the nature and extent of services provided to individuals under Articles V, VI, and VII of the Public Aid Code. The Provider shall maintain said records for not less than three (3) years from the date of service or as required by applicable Federal and State laws, whichever is longer, and shall furnish these records upon demand when so requested by the HFS, Waiver Agency or their designees. If a HFS or Waiver Agency audit is initiated the Provider shall retain all original records until the audit is completed and every audit issue has been resolved, even if the retention period extends beyond the required period.

9. The Provider, if not a practitioner, agrees to comply with the Federal regulations requiring ownership and control disclosure found at 42 CFR Part 455, Subpart B.

10. The Provider agrees to exhaust all other sources of reimbursement as required by Medical Assistance Program policy prior to seeking reimbursement.

11. Provider agrees to be fully liable to the HFS and Waiver Agency for any overpayments which may result from the Provider's submittal of billings to the HFS and Waiver Agency. The Provider shall be responsible for promptly notifying the HFS and Waiver Agency of any overpayments of which the Provider becomes aware. The HFS and Waiver Agency shall recover any overpayments by setoff, crediting against future billings or by requiring direct repayment to the HFS and Waiver Agency.

12. The Provider (if a hospital, nursing facility, hospice or provider of home health care or personal care services) agrees to comply with Federal requirements, found at 42 CFR Part 489, Subpart I, related to maintaining written policies and providing written information to patients regarding advance directives.

13. The provider certifies that there has not been a prohibitive transfer of ownership interest to or in the provider by a relative who is terminated or barred from participation in the Medical Assistance Program pursuant to 305 ILCS 5/12 - 4.5.

14. The provider certifies the following owners/stock holders own 5% or more of the stock/shares. If additional space is needed, please use separate page. If there is no information to disclose, write NONE.

_____	_____	_____
Name	Social Security Number	% of ownership
_____	_____	_____
Name	Social Security Number	% of ownership
_____	_____	_____
Name	Social Security Number	% of ownership

15. The Provider agrees and understands that knowingly falsifying or willfully withholding information on the Provider Enrollment Application and/or the Agreement for Participation may be cause for termination of participation in the Illinois Medical Assistance Program.

    This agreement becomes effective ____/___/_____, which is the earliest date that services were provided to an Illinois Medical Assistance Program client. The Provider certifies that all services rendered on or after such date were rendered in compliance with and subject to the terms and conditions of this agreement.

PROVIDER:

by: _____
(Provider Signature)

_____
(Provider FEIN Number)

Date: _____

FOR STATE AGENCY USE ONLY

WAIVER AGENCY:

by: _____ _____
Authorized Agency Signature Date

Title: _____

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES:

by: _____ _____
Authorized Agency Signature Date
Division of Medical Programs